North Carolina Department of Health and Human Services
Division of Social Services
Designation of Authorized Representative

FROM: _____ **DATE:** _____

ADDRESS: _____ **COUNTY:** _____

CITY _____ **ZIP CODE:** _____

TO: Director, _____ **County Department of Social Services**
(Attention: Food Stamp Program)

Please check all boxes that apply:

☐ **I wish to apply for the Food Stamp Program, and I have appointed the person whose name and address appears below to make the application, to be interviewed if necessary, and to sign the Food Stamp Program Application, on behalf of my household. This person knows my circumstances well enough to answer any questions for Food Stamp Program purposes. I fully understand that my food stamp unit is responsible, by law, for any statement, written, or oral, made by the person whose name appears below which has an effect on the eligibility of my food stamp unit for the Food Stamp Program.**

☐ **My representative has been designated on the application form to obtain my benefits and purchase food for my family.**

_____ _____
(Signature, Head of Food Stamp Unit or Spouse) **(Date)**

☐ **I have Power of Attorney for and will represent the person whose name appears above in applying for the Food Stamp Program, obtaining benefits, and purchasing food for the household.**

☐ **I have been asked by, and agree, to represent the person whose name appears above in applying for the Food Stamp Program.**

☐ **I have been asked by, and agree, to obtain benefits and purchase food for the person whose name appears above.**

Name, Authorized Representative: _____

Social Security Number: _____ **Date of Birth:** _____ **Race:** _____ **Sex:** _____

Address: _____

Phone Number: (_____ **)** _____

Name of Alcohol/Drug Treatment Center: _____

Address: _____

Phone Number: (_____ **)** _____

_____ _____
(Signature, Authorized Representative) **(Date)**

For Office Use Only

A/R Approved ☐ **FSIS ID#** _____

Disqualified ☐

Disqualification Period From: **To:** _____

Agency Disqualification Override Date and Reason: _____

Override Authorized BY: _____

Distribution: Original: Case Record **Copy: Authorized Reparesentative** **Copy: Food Stamp Unit**